

**State of Connecticut**  
**Department of Consumer Protection**  
**Commission of Pharmacy**  
165 Capitol Avenue, Room 147  
Hartford, CT 06106 - Telephone: 860-713-6070



## **Pharmacy Intern Preceptor's Statement**

*Part I: To be completed by the Pharmacy Intern*

**I hereby certify that I am a registered intern in the State of Connecticut.**

Registration Number: PCI. \_\_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**I certify under penalty of law that the information provided in this statement is true to the best of my knowledge.**

Name of Intern: \_\_\_\_\_  
(First, Last)

Signature of Intern: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Part II: To be completed by the Pharmacist Preceptor*

**I hereby certify that I am a licensed pharmacist in the State of Connecticut.**

License Number of pharmacist preceptor: PCT. \_\_\_\_\_

I am the preceptor who supervised the training of \_\_\_\_\_  
(Name of Pharmacy Intern)  
for the purpose of gaining intern practical experience, as required by  
Section 20-598 of the Connecticut General Statutes and Section 20-576-8 of the  
Regulations of Connecticut State Agencies.

**I hereby certify that a total of \_\_\_\_\_ internship hours were earned  
from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ under my  
supervision at the following pharmacy:**

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City/Town)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

License Number of pharmacy: PCY. \_\_\_\_\_

**I certify under penalty of law that the information provided in this statement is true to the best of my knowledge.**

Name of Pharmacist Preceptor: \_\_\_\_\_  
(First, Last)

Signature of pharmacist preceptor: \_\_\_\_\_

Date signed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_